

Pediatrics of Parents

The newsletter for people who care for children

Richard J. Sagall, MD, Editor

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Smoking and Sleep Problems

Add another detrimental effect of smoking on babies to the list – sleep problems. The sleep duration of breastfed infants of smoking mothers was measured in two situations: when the mother smoked a cigarette just prior to breastfeeding and when she refrained from smoking for 12 hours before breastfeeding her baby.

Most breastfeeding experts don't consider maternal smoking a reason not to breastfeed. However, mothers who smoke generally wean their babies sooner than their non-smoking peers. The reason may be that sleep-deprived infants are fussier than other babies who get enough sleep. The fussiness goes away when the mother doesn't breastfeed (due to the lack of nicotine) and the baby sleeps better.

There's another adverse consequence of maternal smoking on children. When these children are adolescents they are more likely to become smokers than adolescents who were not exposed to nicotine as a baby.

Family Practice News, 9/15/07

Petting Zoo Dangers

There's nothing cuter than seeing a toddler pet a soft bunny in a petting zoo. But it may endanger that child's health. There's a long list of potentially illness-causing germs that children can pick up from cute little farm or zoo animals: *E. coli*, *Cryptosporidium*, *Salmonella*, Orf virus, *Coxiella burnetii*, and *Giardia* species.

What's the best prevention? Close all petting zoos! But that's not a practical, or popular, solution. Hand washing is best, but it must be done and often it's not. A recent study found that only one-third of visitors to petting zoos washed their hands upon exiting the zoo. And many objects that could be contaminated (baby bottles, pacifiers, spill-proof cups, toys, etc.) were not cleaned at all, let alone properly.

The first step is for all petting zoos to have hand hygiene facilities located at all exits, post reminder signs, and have a source of running water. Petting zoo staff should remind all petters – children and adults alike – to wash their hands, and even show them how to do it properly. To further help prevent the spread of germs, food vendors shouldn't be located near petting zoos.

Consultant, 9/1/07

Childhood Hearing Loss: Acting Early Improves Language Skills

By K. Todd Houston, PhD, CCC-SLP

Was your baby screened for hearing loss when he or she was born? If you can't answer that question, you're not alone. Although nearly 80% of mothers recently said they were familiar with newborn health screenings, less than half knew the screenings for their newborn sons and daughters most likely included a hearing screening, according to a survey conducted for the Alexander Graham Bell Association for the Deaf and Hard of Hearing (AG Bell).

Today, more than 90% of all newborns are screened for hearing loss before leaving the hospital. That's important because hearing loss affects 12,000 children born in the United States each year, making it more common than other serious conditions, such as Down Syndrome or cystic fibrosis. And, the sooner a child is diagnosed with hearing loss, the better.

What Is Newborn Hearing Screening?

Universal newborn hearing screening can identify most newborns at risk of hearing loss. Hospitals use one of two simple tests to help determine infants' sensitivity to speech and other sounds in their environment.

The first, known as the auditory brainstem response, or ABR, measures the brain's response to sound using earphones and small electrodes, which are taped to the baby's head. The second, otoacoustic emissions testing, involves inserting a small tipped instrument into the baby's ear to measure inner ear function. Both methods use automated hearing screening machines and are not painful, so even a sleeping baby's hearing can be measured in just a few minutes.

Currently, 38 states and the District of Columbia mandate universal newborn hearing screening. In states where screening is not mandatory, guidelines from the U.S. Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH) urge parents to ensure their child receives a screening before one month of age.

Why All the Fuss?

Infants and toddlers begin to learn language long before they can talk, and hearing is a key part of this process. Most young infants will move their eyes in the direction of a loud sound. By three months to six months

old, they'll know the sound of their parents' voices. But babies need to be able to hear to help them understand the sounds – and the world – around them.

Infants and toddlers with an undiagnosed hearing loss often have trouble understanding what is being said or learning to talk. In elementary school, children with unmanaged hearing loss may find it difficult to learn to read, write and communicate with teachers, classmates and friends. Over time, those challenges can lead to a sense of isolation and other issues that can affect a child's social and emotional development.

Fortunately, technologies available today, such as hearing aids and cochlear implants, combined with early intervention, can help children with hearing loss develop language skills comparable to their hearing peers by the time they enter first grade.

What If My Baby “Fails?”

Babies who “fail” the newborn hearing screening should be referred for follow-up and diagnosis before they are three months old by a hearing specialist known as an audiologist.

Even at that young age, babies can be fitted for hearing aids. Additionally, cochlear implants – electronic devices implanted behind the ear to convert sound waves into electrical impulses that enable a person to hear – can help children as young as 12 months. An estimated 11,000 children in the United States currently have a cochlear implant.

Experts also recommend beginning family-centered early intervention programs that focus on listening, speech and language skills before a baby is six months old to take advantage of the critical time window for learning language, which is during a baby's first months and years.

Babies Who “Pass” Screening

It may seem like a big relief when a baby passes the universal newborn hearing screening, but it's not that simple. Deafness is an invisible handicap, and up to 30% of children can develop hearing loss after birth.

One way parents can help is by making sure their infant or toddler meets developmental listening and talking

milestones (see sidebar). Parents whose children who are not meeting these targets should ask their pediatrician or other primary care provider for a referral to an audiologist who can test for hearing loss.

Managing Hearing Loss

Parents who discover their child's hearing loss at an early age can help them to develop listening and language skills comparable to their hearing peers, if they are aware of all their options. Yet, as AG Bell's survey found, 68% of families said that before being surveyed, they had not been sufficiently informed about spoken language as an option for children with hearing loss, although nearly all would be inclined to explore spoken language if their child were diagnosed with hearing loss.

To help make parents and others more aware of these important issues, AG Bell has launched the Hear from the Start, Talk for a Lifetime campaign. Over the next five years, AG Bell will reach out to parents, primary care providers and other professionals in communities across the United States to ensure that all families have access to the information they need to effectively manage pediatric hearing loss. And that means giving parents information they need every step of the way – starting with newborn hearing screening.

Dr. Houston is executive director & CEO of the Alexander Graham Bell Association for the Deaf and Hard of Hearing. For more information about AG Bell and the Hear from the Start, Talk for a Lifetime campaign, visit www.agbell.org.

Strep Throat

By Robert S. Van Howe, MD, MS

Sore throat is a common complaint in children and adolescents and accounts for a high percentage of visits to a physician. The sore throat can be the result of a viral infection, most commonly adenovirus or Epstein Barr virus (the virus responsible for infectious mononucleosis), a bacterial infection, or post-nasal drip. While viral infections will resolve spontaneously and the source of the post-nasal drip (often sinusitis, a common cold, or nasal allergies) needs to be explored separately, the most common fear is that the sore throat is caused by Group A streptococcus – the dreaded strep throat.

If untreated, strep throat will resolve itself in about four to five days. If it gets better by itself, then why do we treat it? There are several reasons. First, early treatment results in a quicker resolution of symptoms. Second, some problems may arise if strep throat is not treated. The more common problem is spread of the infection to behind the tonsils where an abscess can form. This serious infection usually requires hospitalization and sometimes surgery. A less common problem is rheumatic fever, which can lead to long-term damage to the heart and, in rare cases, death.

While antibiotics can shorten the duration of symptoms if given early enough, they can cause adverse effects such as diarrhea, vomiting, and allergic reactions. The most severe form of allergic reaction, anaphylaxis shock, can cause death. Indiscriminate antibiotic use has also been linked to bacterial antibiotic resistance. More surprising is that most people with strep throat never seek medical treatment.

Currently, there are six approaches to the diagnosis and treatment of strep throat. These are:

- 1) Treat all suspected cases with antibiotics
- 2) Observe without testing or treatment
- 3) Treat those with positive rapid diagnostic tests (strep screen)
- 4) Treat those with positive throat cultures
- 5) Treat those with positive rapid diagnostic tests, but obtain a throat culture on those with a negative rapid diagnostic test and treat those with a positive culture
- 6) Use a clinical scoring measure to determine the diagnosis/treatment strategy

Each approach has its strengths and weaknesses. The first approach, treating all patients with sore throats without testing, has the advantage that no case of strep throat that presents to the physician goes untreated. Unfortunately, this approach involves treating 70% to 90% of patients with sore throat who do not have strep throat. These patients face all the risks of taking antibiotics with none of the benefits.

The second approach, observing all patients without providing testing or treatment, saves the costs of testing and of treatment, and the risks associated with antibiotic use are avoided. While nearly all cases of strep throat will clear spontaneously, early treatment may decrease the symptoms of strep throat by one or two days and avoid the risks associated with untreated strep throat.

The third approach, testing all sore throat patients with a rapid antigen test and treating those with a positive test with antibiotics, will identify nearly all individuals with strep throat and avoid antibiotic use in those with sore throat from other causes. The test will miss only a few patients with strep throat, who then face the risk of untreated disease.

The fourth approach, testing all patients with a throat culture and treating those with a positive test with antibiotics, has the advantage of missing few cases of strep throat, but the disadvantage of a two-day delay in making the diagnosis before treatment can be initiated. This increases the time the patient with strep throat feels ill and parental time lost from work.

The fifth approach, testing all patients with a rapid antigen test, treating those with a positive test with antibiotics, and performing a culture on those with a negative test, is a very popular approach. It allows most patients with strep throat to initiate therapy immediately and eventually identifies nearly all cases of strep throat. It does, however, add the expense of a second test to the 70% to 90% of patients who do not have strep throat, while identifying very few additional cases of strep throat.

Finally, a clinical scoring system to triage the diagnostic approach would ignore those with a low score, test and treat the positives with an intermediate score, and treat without testing those with a high score. This scenario combines the advantages and disadvantages of the other approaches.

A cost-utility analysis uses the best information available to estimate the likelihood of all the possible outcomes and the financial costs and health consequences of each of these outcomes. With this information, the average financial cost and health outcome for each option can be estimated. Because of the many options we attempted, using a cost-utility analysis to determine the costs and health impacts of each of these options helped us decide which option served our patients best.

Our calculations found that the first approach, prescribing antibiotics to everyone with a sore throat, on average, had the poorest health outcome. Testing and treating no one had the best health outcome but the highest cost. This result is interesting on two levels. Most of the cost was attributed to a parent having to miss work to stay at home with the sick child. The inclusion of this cost in cost-utility analysis is a standard feature, but not without controversy. If the cost of a parent missing work is excluded, the no testing/

no treatment option becomes the least costly option. This option had the best health outcome because an adverse reaction to an antibiotic is more likely than an adverse complication of an untreated strep throat. The other treatment options are very close to one another. Of these, using a rapid detection method appeared to be preferable unless the cost of a throat culture was much less than the cost of the rapid test.

Do these results mean that we should stop testing and treating children for strep throat? Maybe, but more information is needed before jumping to that conclusion. Our model is highly dependent on the reliability of the available information, especially the risk of peritonsillar abscess and the risk of rheumatic fever following untreated strep throat. The available estimates of these risks are outdated and of questionable validity. For example, the risk of peritonsillar abscess following untreated strep throat has been estimated to be as high as 1%, yet peritonsillar abscess is rarely seen in clinical practice despite most strep throat patients never seeking medical care. Likewise, the only estimates of the risk of rheumatic fever following untreated strep throat come from a study published in 1961. Since then, evidence suggests that the risk of rheumatic fever has been reduced fifty-fold. Most cases of rheumatic fever today occur in children who cannot recall having an infection with Group A streptococcus.

Before the question of whether strep throat needs to be tested for or treated can be answered, more accurate estimates of the risk of peritonsillar abscess or rheumatic fever following Group A streptococcal infection are needed. Meanwhile, it is best to use a rapid diagnostic test as it affords earlier treatment, which leads to early resolution of the symptoms. Narrow spectrum antibiotics, such as penicillin or first-generation cephalosporins are effective, less costly, and less likely to disrupt the natural balance of bacteria in the body.

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Hiccups in Babies and Children

By Randell Wexler, MD

What Are Hiccups?

The medical term for hiccups is singultus and comes from Latin. It means sobbing while catching your breath. Hiccups occur due to an involuntary spasm of the muscles that help us to breathe, including the diaphragm (the large muscle that divides the chest from the abdomen) and the muscles around the ribs. These spasms cause the muscles in the throat to spasm, producing the usual sound. Hiccups may occur up to sixty times a minute, though for most people the frequency is much lower. Hiccups are a common and usually benign problem that will affect everyone at some point in time.

What Can Cause Hiccups?

There are many harmless causes of hiccups. In babies, taking in too much air while feeding is often the cause. In older children, common reasons include over-eating (which causes the stomach to become distended), and drinking too much soda (the carbonation is the cause here). Sudden excitement and stress are also thought to be possible causes. Another common cause of hiccups is gastroesophageal disease (GERD), which occurs when acid leaves the stomach and rolls up into the esophagus (the food tube). Your doctor can determine if GERD is causing your child's hiccups. Rare, but more concerning, causes include medication side effects, medication overdoses, infections, and multiple sclerosis.

Hiccups are rarely related to a health problem in babies. When babies do have hiccups it is usually during feeding. If this occurs, it is OK to continue feeding the baby, as he will not choke. The windpipe going to the lungs has a cap on it called the epiglottis, which closes during the hiccup and will keep the milk or formula out. Babies do not get upset from hiccups, which eventually go away on their own. You do not have to do anything.

When Should I be Concerned About My Child's Hiccups?

If your child complains of stomach pain or coughs up blood you should notify your child's doctor. If the hiccups began after starting a medication or last for more than three hours, you should also notify the doctor.

How Can I Stop My Child's Hiccups?

First do nothing. Hiccups will stop by themselves and the home remedies that people try to stop hiccups often coincide with the hiccups stopping on their own.

However, if you would like to try something, the following home treatments have been reported to be of help: 1. Drink a glass of water (but not from the opposite rim!); 2. Have your child hold his/her breath; 3. Have your child suck on a lemon wedge; 4. Put some sugar or peanut butter (but make sure there are no peanut allergies) on your child's tongue; and 5. Have your child sneeze. Although nobody knows for sure why any of these treatments seem to work, they are probably related to influence on the vagal nerve, which is the nerve that controls breathing.

If hiccups last longer than a few hours or have a medical cause, your child's doctor may recommend specific treatments to target the underlying problem. For GERD, the treatment is usually acid suppressants in combination with dietary changes. Medications are sometimes used for chronic hiccups and include muscle relaxants, and anti-seizure drugs. If neither of these works, acupuncture or hypnosis may be tried. Finally, if all else fails, your child's doctor may suggest surgery to cut part of the vagal nerve.

The bottom line is that hiccups are a common problem in babies and children, and in the vast majority of cases are not harmful.

Dr. Wexler received his undergraduate degree from Miami University in Oxford, OH, his medical degree from Wright State University in Dayton OH, and his Masters in Public Health from The Ohio State University. Dr. Wexler is currently an Assistant Professor of Clinical Family at The Ohio State University.

Top Baby Names

2005	Jacob	Emily
1995	Michael	Jessica
1985	Michael	Jessica
1975	Michael	Jessica
1965	Michael	Lisa
1955	Michael	Mary
1945	James	Mary
1935	Robert	Mary
1925	Robert	Mary
1915	James	Linda
1905	John	Mary

Social Security Administration



Children in Hospitals

By John E. Monaco, MD

The Dangers of Inhalants

He told his friends that it was completely safe. It could get you high, it was easy to find and in almost any grocery store, and it was cheap. There was no way anyone could find out about it, and the cops never arrest you for it. He enticed young girls into trying it and convinced them that it was the safest – and cheapest – way to get high. What was his wonder drug? Nitrous oxide. That's right, the same drug that dentists use to dissociate a patient's consciousness from the rest of his operative nervous system. This young 10th grader, I'll call him Frankie, was a major user of the stuff.

Nitrous oxide is easily available and all the kids know about it. Sometimes there will be a tank of it at a party, or at night clubs. Balloons are filled with it and patrons can purchase a "hit." There was a girl in Tampa, FL some years back who inhaled the contents of a balloon filled with nitrous oxide, became immediately light headed, fell back, hit her head and died. "You should always sit down when you're huffing," Frankie protectively tells his future fellow abusers of Nitrous.

Frankie gets his nitrous oxide from "whippets," little cartridges designed for whipped cream containers and distributed to major bakers. You can buy boxes of them quite inexpensively. Interestingly, it is sometimes easier to find whippets at "head" shops than at grocery stores. This gives you some idea of the acceptance and wide usage of this drug.

There are far more dangerous drugs that kids inhale for fun and to get high. We had a boy in our community recently who enjoyed sniffing Freon, the gaseous refrigerant used for air conditioning. He had become so accomplished at it, and so addicted to the effect, that he would sneak around to the outside air conditioner units of neighbors and drain the Freon so he could inhale the fumes. On top of the risk of sudden death, Freon is extremely toxic to the liver; its effects of which can be irreversible.

Toluene, which is found in gasoline fumes as well as paint thinners and correction fluid (know anyone who likes to sniff "White Out"?), can result in loss of brain tissue mass as well as injury to kidneys and liver. Trichloroethylene, a solvent, can cause cirrhosis of the

liver as well as hearing and visual damage. Other drugs that are sniffed by kids include amyl nitrate ("poppers"), benzene (gasoline), methylene chloride (degreasers) and many others. All have the capacity for sudden death by asphyxia or even cardiac effects, not to mention the individual toxicity of each individual agent.

Of the many drugs that are inhaled in this manner, nitrous oxide may be one of the safest. However, the mere fact that one's lungs can be filled with the stuff, at a very rapid rate (the dentist very carefully controls how much he administers to you, and at what rate) means that asphyxiation can occur by displacing oxygen from the lungs, or suffocation can occur by simply blocking the ability of oxygen to get into the lungs as it normally would.

The astounding thing about huffing to get high is that while nearly every kid knows about this practice, almost no adult does. At the same time, the reputation of these drugs with most kids is that they are safe. Sure, they know of the odd death that has occurred, but in their customary invincibility, most kids think that such untoward effects could never happen to them.

Those of you who have kids in middle and high school, even in elementary school for that matter, should be aware of the extremely common use of inhaled agents for recreational use. Because they do not have the high profile of cocaine, ecstasy or even marijuana, there is very little mention of them in the mainstream press. Keep your eyes and ears open. Be very careful of unsupervised parties, particularly in middle school. Most importantly, pay attention to your kids and all of their subtleties.

Frankie, the boy who enjoyed whippets, eventually graduated high school but did not go on to college. Nitrous oxide is not his only drug, nor is it the thing that will most likely kill him. He was one of my daughter's classmates, and she was one of the girls he tried to entice to try huffing because it was such a quick, great high and because it was so "safe." She didn't try it that night; something didn't seem quite right to her. The next day she told me about Frankie and his inhaled drug use, and how lots of other kids had tried it but she felt nervous about it. "Is it really safe, like Frankie says?" she asked me. In response, I armed her with

articles and case studies and told her to share them with her friends. Of course she never did. But what she did do was not inhale drugs, and perhaps by example, she convinced other kids that listening to Frankie, and other kids like him, was not in their best interest.

John E. Monaco, MD, is board certified in both Pediatrics and Pediatric Critical Care. His new book, Moondance to Eternity, is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.

Should I Get My Daughter Immunized Against HPV?

By Aimee Alderman-Oler, MA

Human papilloma virus – commonly known as HPV – is a sexually transmitted virus responsible for genital warts and most cases of cervical cancer. There are various strains, some of which cause genital warts. Two of these strains can cause cancerous lesions on the cervix. Gardasil protects against both of these. According to the Centers for Disease Control and Prevention (CDC), there are over 10,000 cases of cervical cancer identified in the United States each year that result in approximately 3,900 deaths per year. There is hope for reducing the rate of cervical cancer, however, and it comes in the form of Gardasil.

What is Gardasil?

Gardasil is the first vaccine developed in the United States to prevent a cancer. It is taken over the course of six months in a series of three shots and may prevent up to 70% of all cervical cancer cases and up to 90% of cases of genital warts. Gardasil is virtually 100% effective against four strains of HPV. (The remaining 30% of cervical cancer cases are not caused by HPV.) Gardasil was approved by the Food and Drug Administration in June of 2006.

Is Gardasil Safe?

Only mild side effects have been reported, such as discomfort at the injection site, low-grade fever and flu-like symptoms. It is known to be effective for at least four years but long-term effectiveness is still unknown. There is always the possibility of a need for a booster shot later in life.

Who Gets the Vaccine?

Gardasil is approved for girls age 9-26. However, it is recommended for girls age 11-12 years. According to Dr. Bobbie Gostout, MD, a gynecologic surgeon at Mayo Clinic, "This allows a girl's immune system to be activated before she's likely to encounter HPV. Vaccinating at this age also allows for the highest antibody levels. The higher the antibody levels, the greater the protection." Although it is not designed to protect women who have already been exposed to the virus, it certainly would not be harmful for a sexually active young woman to receive it.

So What's the Problem?

Well, the controversies are not over the vaccine itself but rather over related issues. For instance, the cost of \$400 for the series of injections can be prohibitive. Also, some wonder if it is too new to evaluate long-term safety. And, Gardasil is still very new. Yet, there has been an unprecedented rush to make it mandatory for young women to receive as part of their routine check ups. Historically, such steps have been taken over the course of many years rather than within a year, as is the case with Gardasil. This rush has led to a question about the motives of the drug industry. However, representatives firmly state that their sense of urgency is driven by the desire to save lives; the more girls inoculated, the more girls protected from deadly strains of HPV. Some critics of the vaccine wonder if young women are more likely to engage in risky sexual behavior if they know they are protected from HPV. This seems unlikely.

What do the Experts Say?

Gardasil quickly earned the support of an advisory panel of the CDC and an endorsement from the Advisory Committee on Immunization Practices. It has been placed on the routine childhood vaccine schedule. Some states are in the process of making it mandatory for school attendance. Clearly, the medical community is in support of this life-saving vaccine.

How's a Parent to Decide?

You need to gather as much information from reliable sources as you can. I asked my family practice physician, and she recommended it. She did caution that there is still a need for cervical cancer screening via pelvic exams (PAP tests) as always (for women over 21 years of age or within six months of beginning sexual activity.) Currently there is no "best" answer, but the evidence is for the vaccine.

Ms. Alderman-Oler received a master's degree in business but has worked for the Center School District in Kansas City, MO for 10 years and is currently a certified parenting educator.



Perspectives on Parenting

By Michael K. Meyerhoff, EdD

Alternatives to Punishment

When it comes to discipline, one of the most effective tools that parents have at their disposal is “operant conditioning,” a fancy term for the common sense notion that if a behavior is rewarded, then it will continue and increase, and if a behavior is punished, then it will decrease and stop. There is no doubt these principles hold up quite well whether you are trying to train a dog to jump through a hoop or teach a child how to act appropriately in a wide variety of situations – particularly during the early years when one’s verbal skills and reasoning abilities are too limited for elaborate explanations to have much impact.

However, while punishment can get an organism to cease undesirable behavior, it can be difficult to control and occasionally may have some unintended and unpleasant additional consequences. There is an old saying: a cat that jumps on a hot stove will never again jump on a hot stove; but the cat will never again jump on a cold stove either... the cat will diligently avoid going near the stove altogether in the future.

So what strategies can parents implement as an alternative to punishment? There are two techniques for eliminating undesirable behavior that may not be obvious but are considerably more precise. And although they may require a little more time and effort, they are equally effective in the long run. One is “extinction;” that is, cutting off whatever is rewarding the undesirable behavior. The other is “differential reinforcement;” that is, rewarding other behavior that is fundamentally incompatible with the undesirable behavior in question.

So let’s say that every time I’m talking on the telephone, my little kid won’t leave me alone. She’s constantly interrupting me, tugging on my sleeve, and otherwise making it impossible for me to have a decent conversation. I keep yelling at her to stop, but to no avail. What can I do to get her to stop bothering me? Well, I could take the back of my hand and crack her a good one right across the face. I don’t think she will bother me when I’m on the telephone after that. On the other hand, I think she won’t come to me and ask me to read her a bedtime story, kiss a boo-boo, or anything else; she will just avoid me entirely.

Alternatively, I can think about what keeps her behavior going. What does she get out of bothering me while I’m on the telephone? Apparently, she craves my attention. Even though I yell at her and there is a nasty tone to the interchange, I give her what she wants. So I need to be totally calm and cool. No matter what she does, I have to ignore her. This may be extraordinarily difficult, as she probably will initially increase her efforts to get my attention. But eventually, if I stick to the plan, she will realize that her behavior is not producing the desired results and it will ultimately fade away because it is not serving her purposes.

A good analogy might be the modern medical treatment for certain kinds of tumors. The standard procedure for an unhealthy growth is a surgical procedure in which it is aggressively removed. While surgical intervention eliminates the tumor, it regrettably often involves the removal of healthy tissue as well – tissue that one would prefer to keep. Today, the highly detailed CAT scans can identify the tiny blood vessels that feed nutrients to a tumor. And using recently developed micro-surgery procedures, those tiny blood vessels can be cut off. With no supply of nutrients coming in, the tumor gradually withers away and dies.

Another area where the “extinction” strategy can be especially suitable is the area of sibling rivalry. Let’s say a little girl constantly fights with her younger brother. Despite all my threats and punishments, the bickering continues unabated. What keeps the behavior going is my attention. After all, that is what the rivalry is all about. In fact, hidden camera studies have shown that brothers and sisters will fight constantly as long as their parents are present. But when the parents are away, the kids tend to get along quite well and typically play together nicely. Therefore, if I simply ignore all the acrimonious arguing and exchange of insults, sooner or later the siblings will realize there is no reward forthcoming and the behavior will dwindle significantly and may even disappear entirely.

And this is where the second technique – differential reinforcement – can be put into the system. Although rare, there are times when the little girl and her baby

brother actually do engage in reasonably pleasant interchanges. At these moments, I can lavish them with attention, praise, and all sorts of other nice stuff. This will lead to the sharing, cooperating, and getting along steadily increasing, which will leave little if any room in their behavioral repertoire for the adversarial interactions.

This second technique – rewarding behavior that is essentially incompatible with the undesirable behavior – is particularly appropriate when applied to activities for which children often find it difficult to get motivated, such as cleaning their rooms, doing their homework, etc. Punishing them for failure to comply and/or complete frequently turns out to be ineffective because the kids see the punishment as no worse than doing what they are being punished for not doing. And they sometimes come to realize that if they routinely endure the punishment, their mothers and fathers eventually will become frustrated and disheartened, and they may give up even attempting to apply punishment (extinction in reverse!).

Consequently, it makes sense to take the alternate route of providing rewards for compliance and/or completion of their assignments. And it may be necessary to do this in small increments. Start by permitting small accomplishments to be met with small rewards then gradually increase both expectations and pay-offs. Eventually, you should start to see performance reach consistently high levels. At this point, you can begin to institute a schedule of reinforcement. That is, after a while, satisfactory compliance and/or completion must be achieved twice before the reward is offered, then three times, then four, etc. After a while, rewarding only once in a while will be necessary to keep the desirable behavior going.

Of course, there still will be plenty of times when punishment may be the more appropriate choice. But to the extent that you can strive to pursue these more positive, albeit more time and energy consuming – alternatives, you may find that managing the behavior of your little one will become considerably less stressful and infinitely more satisfying.

Michael K. Meyerhoff, EdD, is executive director of The Epicenter Inc., “The Education for Parenthood Information Center,” a family advisory and advocacy agency located in Lindenhurst, Illinois. He may be contacted via e-mail at epicntrinc@aol.com.

Need A Holiday Gift?
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Measuring Blood Pressure

It should be easy – put on the blood pressure cuff, pump it up, slowly let out the air and listen for the beat with a stethoscope. And there you have it – a blood pressure reading! If it were only that simple.

Many factors can influence an accurate blood pressure reading – body position (sitting, standing, or laying down), how relaxed the person is, anxiety, and the hearing acuity of the person taking the blood pressure. In children with hypertension (high blood pressure), relatively small inaccuracies may mean the difference between “well controlled” and “poorly controlled” blood pressure.

A study of 390 children with high pressure who were seen at the Pediatric Hypertension Clinic at Texas Children’s Hospital in 2003 and 2004 found a significant difference in blood pressure readings taken at a vital signs station and in an exam room. The study wanted to compare the blood pressure readings that were taken at a “standard practice vital sign station” with those taken in an exam room and according to standards set forth in *The Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents*.

The researchers found that 74% of the readings were higher at the vital signs station. For the systolic reading (the top number), the mean (average) difference between the vital signs station and the exam room was 13.2 mm Hg (millimeters of mercury); for the diastolic (the bottom number) the mean difference was 9.6 mm Hg. Only 12% differed by less than five mm Hg for both systolic and diastolic readings. Each millimeter of mercury is one point in the measurement of blood pressure.

The concern about the discrepancy between vital signs station readings and exam room readings (using the standards in the Report) is that one elevated blood pressure reading at a vital signs station should not indicate a diagnosis of hypertension. If your child has one elevated blood pressure reading, don’t panic. Multiple readings should be taken when your child is relaxed and lying down. Only if multiple readings are elevated should a diagnosis of pediatric hypertension be considered.

Pediatrics, 3/07

The holiday season is upon us, and families are busy shopping for toys for children. With all the recalls in the news this past year, parents feel there are few toys to choose from that are safe for kids. The Consumer Products Safety Commission (CPSC) says the toys that pose the most danger are those that pose choking or aspiration hazards – toys with small parts that can be easily swallowed. These include toys with small magnetic pieces that can attract to each other if accidentally ingested. The CPSC believes that Awareness Benefits Consumers – or “ABC.” Below are their suggestions for safer toys, regardless of the time of year:

Awareness – Know what toys pose the greatest risks and that there is a CPSC whose job it is to help protect consumers.

Benefits – The number of recalls has increased the scrutiny under which toy manufacturers and distributors make and sell toys. More toys than ever are being inspected and, if necessary, removed from the marketplace.

Consumers – Communication is key to staying informed about recalls. Consumers can receive direct notification of recalls by going to the CPSC website, www.cpsc.gov.

Pediatrics for Parents recommends the following when purchasing and using toys and children’s gear:

- Buy toys that are age-appropriate. Check the recommended ages on the packaging and make sure you don’t buy toys that are too old for the child. Age-appropriate toys suit the ability, age and skill level of that age group. Buying toys that are too old for children may result in their being disappointed or frustrated because they can’t use or understand the toys correctly. And, there may be pieces that are too small for a younger child.
- Don’t buy toys with small magnetic pieces for any child under age six. We recommend that you not buy such toys for any child younger than 10, especially if that child has younger siblings who could easily access the pieces.
- Use toys and gear according to the manufacturer’s instructions.
- Keep batteries out of children’s reach. If opened, batteries contain acid that can be toxic if swallowed.

- Keep charging units and adapters out of children’s reach. They can get hot when in use and pose a burn hazard to young children.
- Discard all packaging and plastic wrapping as soon as toys are opened. Lots of toys are packaged with small plastic twist-ties that pose a choking hazard to small children.
- Keep scissors, screwdrivers and any sharp tools off the floor and out of children’s reach when opening and assembling toys.
- Call the toy or gear manufacturer if you have questions about how to assemble or use a toy or gear. The toll-free number or website should be listed on the packaging or in the instruction manual.

Pediatrics for Parents wishes you a safe and happy holiday season.

Vikki Sloviter received her BA in History of Science and Medicine from Yale University. She lives in Bucks County, Pennsylvania with her husband and three children. She also proofreads, copy edits, researches and writes for Pediatrics for Parents and NeedyMeds.com.

Ear Infections and Snoring

Children who snore are almost twice as likely to have recurrent ear infections (recurrent otitis media - ROM) than non-snoring kids. The snorers were almost three times as likely to have tympanostomy tubes (ear tubes) than children who don’t snore.

This study of 16,321 children five to seven years old found 11% were habitual snorers (snoring three or more nights per week). Sixteen percent of the habitual snorers had a history of ROM and 24% had ear tubes in place. Only 9% of non-snorers suffered from ROM and 9% had ear tubes.

Although there is an association between habitual snoring and ROM, it’s not known if one causes the other or, more likely, if there is a common cause for both problems. More studies are needed before the possible relationship will be clarified.

Pediatric News, 9/07

Children and Food Allergies

By Maura Steblay

Anaphylaxis is a serious allergic reaction with effects ranging from rapid heartbeat and hives to lightheadedness or loss of consciousness. It is a parental nightmare to watch a child suffer from anaphylaxis. Most food allergies are much milder than anaphylaxis. The investment you make in determining your child's food allergies now will promote a healthy and safe future for her and piece of mind for you.

A food allergy develops when the body's immune system becomes misdirected and attacks harmless food proteins. As a result, the immune system designed to fight infection and disease creates antibodies to fight the food allergen that triggered the allergy. During an upcoming exposure to that food, whether through touching it, eating it, or inhaling its particles, the body releases chemicals, including one called a histamine, to protect itself. The result of this hypersensitivity is an allergic reaction, which may range from sneezing to eczema to anaphylaxis.

Causes

Food allergies affect nearly six million Americans. The tendency to be allergic to food in general is likely genetic. The chances a child will develop an allergy are two to five times greater if either or both of the birth parents have a history of allergies. Food allergy is more common in children than in adults; six to eight percent of infants younger than age two are allergic to some food.

While any food can cause allergies, 90% of all food allergic reactions are caused by "the big eight" – egg, fish, milk, peanut, shellfish, soy, tree nuts (walnut, pecan, etc.), and wheat. One in every three Americans modifies his diet in the belief that he or a loved one has a food allergy although oftentimes discomfort is caused by a food intolerance rather than food allergy.

Diagnosis and Identification

A RAST test (RadioAllergoSorbent Test) is a blood test measuring the level of allergen-specific antibodies. It can be ordered by your child's physician. A RAST test is not designed to pin down the cause of a reaction. It simply indicates if a reaction has produced antibodies called IgE (a protein produced by white blood cells which calls up the allergic reaction forces).

It is interesting to note allergies are part of a common trio: allergies, eczema, and asthma. A child suffering from one is more likely to exhibit signs of the other two. Many symptoms, whether allergy-caused or simply allergy-like, may disappear as the physical development of the child continues and the immunological system matures. For example sensitivity to milk, eggs, or soy tend to resolve with age, whereas allergy to peanuts and tree nuts often begins in infancy but fails to diminish with age.

Feeding Your Child with Food Allergies

How do you feed your child with a family allergy history? Remember the advice your child's doctor gave you as your child reached solid food age. When introducing a new food wait several days before introducing another first-time food to ensure no allergic reaction develops. Peanuts, tree nuts, and shell fish should ideally be introduced to children after age 36 months to five years. In general an allergy doesn't always show up on the first exposure but eighty percent of peanut allergic individuals developed symptoms on their first known exposure.

Second, take advantage of bridging foods: mixing a familiar or safe food with an unfamiliar one. Bridging varies from the above-mentioned method in that it provides a launching spot for your child. A familiar food or texture may allay some of your and your child's fears about new foods that are introduced. Again, this method will assist in your attempt to narrow the field to determine what food actually caused a problem while allowing you greater variation with meals and foods. Remember, one in every three Americans modifies his diet because he believes he has a food allergy when in fact he has a food intolerance.

Another suggestion is to keep a food diary. A food diary provides helpful and complete data on the specifics of ingestion as compared to an allergic reaction – a most useful tool in the diagnosis of possible food allergy. Foods eaten, liquids ingested, as well as the timing of any and all symptoms should be recorded. Some doctors even recommend noting brand names and all of the ingredients in processed foods whenever possible. The culprit may not be the food itself but other additives. A simpler method may be to retain the ingredients list or keep an extra container for later referral.

Preventative Action

In children, allergies can have much more serious physical and social long-term affects than they do in adults. Here is a list of considerations for children with allergies:

- Allergies may be a cause for extended school absences and poor school performance.
- Chronic allergy care can disrupt normal family activities and interrelationships.
- Nasal allergies trigger serious, recurring ear infections and chronic headaches in many young children.
- Allergy medications – especially those used to treat asthma – can be disagreeable to take and may cause side effects ranging from unpleasant to dangerous.
- Asthma is much more common and severe in children – in some cases life threatening.
- Eczema commonly starts in early childhood; 90% of sufferers have symptoms before age five.

If your child has a known allergy, be aware of other names for the same ingredient. For example cheese made from soy or rice may contain whey or caseinates, a common dairy allergy ingredient.

Read labels and help the school and others by providing them with accurate information. Parents must take the lead in regards to their children's allergy safety, its symptoms and treatment to give the child the best possible scenario of allergic reaction avoidance. A written food allergy action plan as well as notification of the allergies will assist your child, the school, and perhaps the parent keeping your child overnight at a slumber party.

Remember to educate your child as well. Teach him to read labels. Even very young children – even four and five-year-olds – can, with proper coaching, learn to manage their own allergies. Help them avoid possible problems by learning to decline sharing other

children's snacks and lunches. For special occasions at school, provide some allergy-safe but fun snacks from your own pantry.

In your role as nutritionist, dietician, and food preparation expert for your child stay active and well informed. Be careful not to harm your child with too much hovering. There are some unusual food-linked complications in significant numbers of allergic children. First, some parents list allergies as the reason behind allowing their children to be sedentary or inactive. Children with allergies do not require a sedentary lifestyle to effectively cope.

Parents often connect a robust appetite with good health. Some parents, therefore, bombard children with food treats and delicacies in the belief that heartier eating will increase their overall good health. Food is not a medicine. A healthy, balanced diet is necessary for all of us, especially children.

In summary, the long-range prognosis for your allergic child is optimistic. Chances are symptoms will be outgrown or, if they continue, will be manageable and perhaps avoidable. Allergies are not a handicap, rather a factual description of a child's genetic makeup just like brown eyes. Feeding children is a team effort.

According to Ellyn Satter, MS, RD, who has written on this topic, "Parents provide structure, support, and opportunities. Children choose how much and whether to eat from what the parents provide."

Maura Steblay is a Minnesota Licensed Parent Educator with a Masters Degree in Education. She is also the president of Parenting Unlimited, which brings parent education to parents in non-traditional venues. She sits on the board of the Foundation for Eden Prairie Schools and the West Suburban Teen Clinic. She has volunteered on the Parent Warmline for Children's Hospitals and Clinics for the past five years.

Additional Sources of Information

The Parent's Guide to Food Allergies, by Marianne S. Barber, MD
The Food Allergy Network (www.foodallergy.org)
American Academy of Allergy, Asthma, and Immunology (www.AAAAI.org)
American College of Allergy, Asthma, and Immunology (www.ACAAI.org)
Allernet, information about allergies and asthma (www.allernet.com)
The National Institute of Environmental Health Sciences (NIEHS) (www.niehs.nih.gov)
Parents of Allergic Children, support group for parents (www.parentsofallergicchildren.org)
Asthma and Allergy Foundation of America (www.aafa.org)

According to the Anxiety Disorders Association of America (ADAA), children can suffer from anxiety in much the same way adults do. The ADAA's current research shows that if left untreated, anxiety disorder may cause a child to perform poorly in school, have undeveloped social skills and be vulnerable to substance abuse. But anxiety can sometimes be tricky to recognize, and not all forms of anxiety lead to serious problems.

The Beginnings of Anxiety

"There are many causes of anxiety and fear in children," says Frank Farley, PhD, a renowned child psychologist who teaches at Temple University and has often been consulted on issues of children and terror. Among the most common causes are school issues such as bullying, fitting in and peer pressure, concerns about terror and their future, and stress at home.

"One thing that can lead to anxiety is [any kind of] transition," Farley says. "The most basic anxieties are probably vague memories of helplessness related to conditions which threaten the very existence of the human infant – being attacked, dropped, annihilated, abandoned, overwhelmed or destroyed. These very basic dreads appear in everyone's dreams, sometimes as confused and overpowering nightmares," says Elizabeth Berger, MD, a child psychiatrist from Elkins Park, PA, and the author of *Raising Kids with Character*. "As children grow, they experience more sophisticated kinds of anxieties," she says.

Allen H. Weg, EdD, a psychologist, founder and director of Stress and Anxiety Services of New Jersey, and a cognitive behavioral therapist in East Brunswick, NJ, agrees that the causes of anxiety in a child vary by age. "Younger children tend to focus on fears of separation or loss of parents, for instance. Preteens and teens are more focused on fear of peer rejection or school failure." Although research is ongoing, Farley says there seems to be both genetic and environmental links to anxiety in kids. "A family history of anxiety and depression can sometimes have an effect," he says. "Parents have an enormous impact on kids. If you have a parent who is anxious, [he] will communicate that fearfulness to the child."

Signs that a kid is struggling with anxiety, Farley says, include constant and unrelenting worrying about everyday activities, constantly checking and rechecking

actions (such as a door lock or a packed school bag) and unrealistic fears that appear for no reason.

Coping with Anxiety

Weg says that one of the best ways to cope with anxiety in kids is to talk with them. "Reflect your understanding of their fear ('I know it feels very scary when Mommy drops you off at nursery and you are afraid.');" provide comforting statements ("Do you remember feeling afraid yesterday? What ended up happening? Didn't you end up having a fun day? Didn't Mommy come back for you at the end of the day?"); provide a grounding or transitional object, like a stuffed animal that the child likes, or a charm that belongs to the parent; reinforce any attempt on the part of the child[ren] to combat their fears, even if unsuccessful."

Farley says that older kids especially need to talk, although they may not necessarily initiate a conversation about their fears. "I am a big fan of talking with your kids," he says. "Kids sometimes just want comfort. The more you reason with them [about their fears], the more effective it becomes."

"In general, the best defense against anxiety is human relationships," Berger says. "Parents (always anxious to do a good job) sometimes feel obligated to solve their children's anxieties on the spot, but what is called for is simply empathic listening, open-mindedness, and devotion to the child's best interest. Parents can offer suggestions – should an especially useful one leap to mind – but in the end the greatest reassurance is simply that one is loved and appreciated." A loving family relationship, Berger says, will provide an inner stability and allow children to learn to soothe themselves against life's fears.

When Anxiety Becomes Serious

Excessive anxiety can be a sign of a serious problem, Berger says, especially if the anxiety seems to interfere with the child's sleep, schoolwork and relationships. She recommends talking with your pediatrician "if a child shows persistent symptoms for more than two weeks, if there is a 'change in personality,' if there is an expression of hopelessness [or thoughts of suicide] by the child, or if there is any suspicion of substance use."

Your child's doctor may refer you to a healthcare professional who can diagnose and treat a serious disorder.

While “run of the mill” anxiety, such as concerns about school, parental divorce and arguments with peers, can be stressful, there are many chronic anxiety disorders that can seriously impact the child’s day-to-day functioning, says Weg. These include:

- Obsessive-compulsive disorder – washing, ordering, checking, counting, repeating and cleaning are just a few
- Specific phobia – fear of heights, dogs, bees, etc.
- Social phobia – intense shyness
- Panic disorder – very intense, physiological arousal symptoms that are scary, like heart racing, shortness of breath, dizziness
- PTSD (Post Traumatic Stress Disorder) – following a trauma, where the symptoms involve hyper-vigilance, nightmares, strong startle response and more;
- Generalized Anxiety Disorder – where the child

seems to have multiple worries about almost everything, always thinking the worst

Weg encourages parents to be advocates for their child’s mental health by seeking out a professional who has experience with the particular type of disorder your child may be experiencing. “Do not be afraid to ask the therapist about his/her experience,” he says.

And is there a link between anxiety and depression? “Anxiety disorders and depression disorders can sometimes co-occur,” Farley says. “There are a lot of ongoing research and treatment options out there.”

Mary Ann Romans is a freelance writer specializing in parenting and healthcare articles. She welcomes all comments and ideas and may be contacted via e-mail at maromans@aol.com. This article first appeared in MetroKids Magazine.

Your Questions Answered

Alvin Eden, MD and Roy Benaroch, MD, answer your questions this month. Dr. Eden practices in Forest Hills, NY. Dr. Benaroch’s practice is in Atlanta, GA. Dr. Eden’s new book, *Positive Parenting*, is now available.

Send your questions to QandA@pedsforparents.com or Pediatrics for Parents, PO Box 219, Gloucester, MA 01931. Please keep them general in nature as we can’t give specific advice nor suggest treatment for your child. All such questions should be asked of your child’s doctor.

Warts

Q My daughter has a few warts on her fingers. Her Dr. has tried three times to freeze them. There are two that are still there. What is our next option? It is getting expensive and I don’t think freezing will work. Please let me know what you suggest.

A Warts in children will almost always go away entirely on their own, with no treatment whatsoever. It may take a few years, but eventually a child’s immune system will notice the wart and successfully eradicate it. Sometimes, the best “treatment” is no treatment at all.

If a wart is painful or cosmetically unacceptable, or if the parents or child just don’t want to wait for it to fall off, there are several options for treatment. None of these work all of the time, so if you’ve tried one and it fails, pick another one.

Salicylate compounds like Compound-W are over-the-counter products that slowly wear a wart down.

They need to be applied once a day, usually for several weeks. They seem to work better if the wart is scuffed with an emery board first, and should be applied by dotting only the top of the wart. These work best for smaller warts.

Liquid nitrogen can freeze off warts and is applied in a doctor’s office. It’s quicker than the do-it-yourself compounds, but it can hurt the next day. Larger warts will need several applications. “Blister beetle juice,” also known as Cantharone or cantharidin, can also be applied at the doctor’s office, sometimes alone or in combination with liquid nitrogen.

Some oral medications (including Tagamet and Griseofulvin) can help eradicate even extensive or large warts, though these prescriptions have not been FDA approved for this purpose. Talk with your doctor about their specific risks and potential benefits. Another non-FDA-approved prescription product that can be tried is Aldara. This product was designed for use on genital warts, but appears to be safe and at least somewhat effective on ordinary warts as well.

Roy Benaroch, MD

Eating Everything

Q What can I do to prevent my 12-month-old boy from putting non-food substances into his mouth? I'm worried that he will poison himself one of these days.

A Short of locking him up in his room all day, you cannot prevent him from putting everything he grabs hold of straight into his mouth. But with common sense, awareness, and some basic knowledge you can usually prevent accidental poisoning.

It is estimated that 50% of all infant and childhood accidents are caused by swallowing poisonous substances. National Institutes of Health statistics show that each year close to one million children under the age of five accidentally ingest dangerous household products. As babies begin to crawl and then walk, they become fast and fearless explorers, and use their hands and their mouths to learn about the world around them.

The great majority of poisonings occur in the home. The most commonly ingested products are medicines and household cleaning solutions, such as: insecticides, laundry bleach, rubbing alcohol, furniture polish, kerosene, and medicines (both over-the-counter and prescription).

There are a few simple rules that must be followed in order to prevent accidental poisonings:

1. Store all medicines in a locked cabinet or on a very high shelf
2. Discard old and unused medicines
3. Use safety caps and covers whenever possible
4. Label all medications
5. Never give your child any medicine in a dark room
6. Do not store cleaning aids under the kitchen sink
7. Never leave infants or young children unattended near medications or near potentially dangerous household products. The kitchen and bathroom are where most poisonings occur.

If you know or even suspect that your child has swallowed a potentially dangerous substance, call your doctor immediately. Many cities have Poison Control Centers, often associated with health departments. If your community has such a center, keep the telephone number where it is easily accessible. The trained personnel in the center can be of great help. Giving them the specific name of the product or medicine and the quantity your child swallowed, as well as when the accident happened, will help them advise you about what

to do. If you cannot contact your doctor or a Poison Control Center, my best advice is to take your child to the nearest Emergency Room as soon as possible.

Sad to say, the facts are that about 2,000 children die each year from poisoning in their own homes. Anticipating the possibility of poisoning and safety proofing your house go a long way in ensuring that you will never have to experience such a tragedy.

Alvin Eden, MD

Penile Pimple

Q How common are pimples (specifically white heads with the hard center) on the penis? I have a nine month old, and I nearly freaked out at his last diaper change, where I saw what I thought was a speck of errant diaper cream that wouldn't just wipe away. I tried to wipe it away but it still stuck and is near his circumcision mark near the tip of his penis. Is this something I need to be concerned about?

A I think what you're describing wasn't a pimple, but a collection of white debris caught under the edge of the foreskin.

Often after a circumcision, a bit of foreskin is left behind. Sloughed off skin cells and other debris, called "smegma," can collect in the little pocket or groove at the edge of the foreskin remnant. This material can be picked away, leaving an open space behind.

Smegma can't be prevented entirely – it's a normal part of having a penis. You can try to prevent the foreskin edge from sticking and collecting smegma by gently pushing it down and applying some clear diaper paste or Vaseline. But parents do not need to be very aggressive about cleaning in the groove there. Smegma really won't do any harm, and aggressively pulling and cleaning this area can make the tissues stick together even tighter, leading to more pain for the baby.

By the way, when performing a circumcision, the surgeon has to decide how much tissue to snip away. If too much is removed, the penis will veer sideways, potentially leading to problems with sexual function. If a little too much is left on, this extra skin will eventually just pull back and become normal skin on the shaft of the penis. This extra skin won't go away until the penis grows as the boy approaches puberty. But it's better to leave a little extra than to cut too much!

Roy Benaroch, MD

Family Council: The Board Meeting Every Family Needs

By Cynthia MacGregor

When an employee has a gripe, a question, or a suggestion, there is a protocol to follow. Of course he can just air his dissatisfaction at the water cooler, which gets it off his chest but won't do anything to resolve the situation. She can drop a suggestion in the suggestion box, if there happens to be one in that office, but then it falls into the Great Void; she has no idea what, if anything was done about her suggestion, or ever will be, or whether it was even considered seriously in the first place. If the employee is lucky enough to have a boss who has an open door policy, she can knock on his door and hope he'll pay attention to her concerns. But, though he means well, he might have his head buried deep in the proposal he was writing or the meeting he's preparing for, or his phone might ring... in short, his divided and distracted attention might be the most she'll get.

But chances are that the company, or the department (in the case of a large company), has regular meetings. And chances are that employees are urged to, or at least welcome to, voice their questions, suggestions, and gripes at these meetings. Just knowing that there is a time and a place when they'll have a chance to speak up about their concerns and vent their feelings gives the employees a good feeling; the company isn't ignoring them. They'll be heard. So instead of grumbling, they continue working, knowing their opportunity will come,

That's one of the functions of a Family Council meeting, too, though hardly the only one. Family Council meetings are the place for family members (parents as well as kids!) to make requests, ask questions, air gripes, and make announcements. Attendance is mandatory. It's incumbent on you, the parent, to make sure there are no valid scheduling conflicts... that you haven't called your Family Council meeting for a time when one of the kids has Scouts, band practice, or some other activity that demands his or her attendance. And it's incumbent on the kids that they not schedule any social activities for that time.

Sunday evenings are a good time in many households for Family Council meetings. With a whole weekend to do homework, the kids should be able to ensure that they can afford the 15 minutes to an hour that the meeting might take. It's not a night when there

are many extracurricular activities for the kids, nor are most parents likely to be stuck late at work on a Sunday evening. Of course if you or your spouse have a job or business that does require your working then, or if you belong to a church that holds services Sunday evening, and you're in the habit of attending them, or your daughter's baton group practices on Sunday evenings, you'll pick another time for Family Council meetings.

Meetings can be weekly, bi-weekly, monthly, or simply whenever needed. The advantages to regular meetings are:

- If everyone knows that every Sunday night, or the first Sunday night of the month, is always Family Council night, nobody will make any conflicting social or other plans for that time.
- If everyone knows that Family Council is coming up soon, it will be easier to hold gripes and problems in abeyance till the next meeting.

But of course, if you have a family that seems to run smoothly, and/or you have only one child, and perhaps a young child at that, you may have little need for a regular meeting, and meetings as needed may be the better plan for you.

In any case, whether you meet weekly, monthly, or on as-needed basis, what are the purposes and uses of a Family Council meeting?

To make major announcements of interest to or with impact on the whole family. Mom got a new job and will be working different hours; Dad got a new job, and the family will be moving to Seattle; the family has outgrown this house and is looking for larger quarters in the same area; the family is going to spend a week at Grandma's beach house on the Jersey shore this summer; it's time for a new car, and after shopping around, you'll be buying one; due to the family-owned business having a bad year financially, cost-cutting measures will have to be put into effect; Uncle Ed is getting married in May, and you're all going to go to the wedding; you're going to be growing vegetables instead of flowers this year in the garden, and though yard work by the kids isn't compulsory, it will be appreciated... and they might get a kick out of helping to grow their own food.

To have a discussion on matters on which you want input from all family members. The family is going to get a new pet, either a cat or a dog - let's discuss the relative merits and liabilities of both, and make up our minds which we want to get; either the family can go visit the relatives in Memphis for two weeks this summer, or the kids can go to summer camp for four weeks, but not both - which do they prefer?

To settle squabbles, hassles and disputes. This is not to be a tattletale session, nor should matters that need to be settled immediately be held over for Family Council meetings, but this is the place to air such gripes as, "Tommy always messes up my room, and then I can't find anything"; "Kim always takes my stuff without asking"; "Vicki gets home from school first and takes the best snacks out of the fridge for herself, and then there's only yucchhy stuff left for me to eat."

To bring up gripes or requests on the part of the kids that are aimed at you parents. "It's not fair that I have so many chores to do now that I get three hours of homework a night since I started high school this year"; "Tony gets a bigger allowance than me, and I do more chores than he does"; "I've had the same bedtime for two years, now, and I think I should be allowed to stay up later now that I'm older"; "The class hamster had babies - can we adopt one?"

The formality of the setting of a Family Council meeting lends weight to any decision handed down within that framework. That doesn't necessarily mean that the kids are going to accept every decision without grumbling... if you work in a business environment that includes staff meetings, don't you sometimes grumble over edicts handed down by the department manager, business owner, or whoever is in charge? But although the kids may grumble, they're less likely to protest, or rebel. They'll complain, but they'll accept the ruling even so.

If your family doesn't presently have Family Council meetings, why not try them out? You'll find that it's a good forum for exchanging ideas, expressing views, presenting requests and complaints, and lending more weight to edicts handed down by you, the parents... the Chairs of the Board.

Author of over 50 published books, Cynthia MacGregor writes on many subjects, but the majority of her books are aimed either at parents or at kids. Some of her books tackle "difficult" topics, such as two books written for kids that explain divorce and one that deals with step-families, one for little kids that explains death, and another for little kids that explain's Mom's new pregnancy. But she also writes on happier subjects, as in the I Love You book, and with a sense of humor when it's called for, as in What Do You Know About Manners?

Remediation: Can Learning Disabilities be "Cured"?

By Joanne M. Friedman, MEd

In 1975 the federal government under the guidance of then-president Gerald Ford passed into law the original Individuals With Disabilities Act (IDEA), giving birth to special education as we know it today. Prior to that time, the only students considered special enough to warrant some effort to ensure their education despite their obvious handicaps were the blind, the deaf, the profoundly retarded, and the severely physically impaired—paraplegics, children suffering brain damage or chronic, incurable illness, and those with severe birth defects. There was no "learning disabled" category prior to 1975.

With the advent of IDEA, the approach to learning problems encountered a major paradigm shift. Students who had previously been relegated to the wood shop or who were on a fast track to drop-out status were given a second look. In many cases there were signs of something going on besides a lack of motivation or hanging out with "the wrong crowd". The concept of

brains unable to learn because of some inherent neural deficit was novel, and was embraced slowly by the general public and the educational system.

The purpose of the law – which was, in fact, a civil rights law, not an education law – was to ensure that handicapped students would not be excluded from school as they had been in the past. The retarded child hidden from polite company wasn't that far in the past, and parents were anxious to take those children from the shadows to the forefront and see to it that they were afforded the best that public education could offer.

As will happen, particularly in connection with the federal government, the letter of the law was eventually overshadowed by interpretations and applications far from the original intent. The spirit of the law became not the assurance that students with learning difficulties would not be excluded, but the guarantee that they would be accommodated to the maximum extent pos-

sible. In many cases the students lost their identities as individuals and became their impairments.

The password in the special education community became remediation. To Webster, remediation is synonymous with cure. The educational system was charged with the curing of learning disabilities ranging from retardation, through all levels of brain damage, into the results of fetal exposure to alcohol and other addictive substances, all the way to the vague “specific learning disability”, whose definition is as elusive as its diagnostic shape.

In 2004 the IDEA was reauthorized under the title “Individuals With Disabilities Education Improvement Act”, and some of the onus was taken off the schools for curing something academically that medical science has not been able to tackle successfully. But still the focus on remediation is unmistakable.

Can learning disabilities be cured? In a word, no. Though the jury is still out on many of the varieties of learning problems, overall it's safe to say that the research has afforded educators a wide variety of suggestions for helping students cope with their learning problems, giving them skills to work around the problem, and offering reasonably well-founded plans for overcoming the immediate symptoms of the disability. A student with retention issues is recommended to over-learn – practice till it comes as second nature – academic skills. Students with reading comprehension problems are taught cues to look for and methods for interpreting the written word successfully. The list goes on.

But can any of this be called “remediation”? Is there a cure lurking in the special ed teacher's bag of tricks that will forever relieve the student of the problem? Will it ever entirely go away? No. No, no, and no.

In the current atmosphere of No Child Left Behind's high-stakes tests (ie: standardized tests on the results of which graduation or some other landmark are based), and the portion of that law that requires special education students to perform at grade level, it is more imperative than ever that parents be alert, wary, and educated. If learning disabilities were curable, they'd be confined diagnostically and remedially to the first grades of elementary school. Why would anyone – even public educators – waste time playing with accommodations and special methods if the problem could simply be cured?

Perhaps, you might argue, it takes longer than elementary school to cure autism or dyslexia. You would be right. It takes, literally, forever. Acceptance of your child's disability does not equate with bad parenting, spoiling, or any other negative imagery you might be

harboring. Until disability is accepted and the impossibility of cure (remediation) along with it, frustration will be your biggest enemy. Avoid punishing your child for not measuring up, and find a better stick by which to measure him. Teaching your child coping skills – mnemonics to help with memory problems, the use of special tools for spelling, calculators and PDA's for math and organizational skills – may not be as romantic as the image of thrusting your child into the special education system and retrieving him at some later date fully cured and ready to function within the vague realm of “normal”, but it will work far better.

Joanne M. Friedman received her undergraduate degree in psychology from Clark University and her MEd in special education from the University of Hartford. A past member of the Council for Exceptional Children, she has spent twenty-five years teaching special education at all levels, elementary through high school to learning disabled, emotionally disturbed, physically handicapped and developmentally disabled children and served on the Learning Disabilities Advisory Board at Sussex County College for six years. Joanne Friedman is a freelance writer living in Sussex County, NJ.

When Toddlers Bite Other Children

By Elizabeth Pantley

A worried mother asks, “Today at our play group my son BIT my friend's daughter! My friend acted like it was a normal childhood problem, and told me not to worry about it, but I'm horrified! Why did my son do this? How can I prevent it from happening again?”

Learn About it

Your friend has obviously had some experience with toddlers, and she knows that biting a playmate is common in this age group (perhaps her daughter has already been on the other side of the action.) Toddlers don't have the words to describe their emotions, they don't quite know how to control their feelings, and they don't have any concept of hurting another person. When a toddler bites a friend, it most likely isn't an act of aggression: It is simply an immature way of trying to get a point across, experimentation with cause and effect, or playfulness gone awry.

What Not To Do About Biting

Many parents respond emotionally when their toddler uses his teeth on another human being; their immedi-

ate response is anger, followed by punishment. This is because we view the act from an adult perspective. However, if we can understand that a toddler bite is most likely a responsive reflex, we can avoid responding in the following typical, yet unnecessary and ineffective ways:

- Don't bite your child back to "show him how it feels." He isn't purposefully hurting his playmate. He doesn't understand that what he did is wrong, so by responding with the same action you may actually be reinforcing that this is an acceptable behavior, or confusing him entirely.
- Don't assume that your child is willfully misbehaving. The ways that you'll treat these behaviors in an older child, who understands that biting is wrong, will be different than how you will approach this with a toddler.
- Don't yell at your toddler. This will do nothing more than scare her; it won't teach her anything about what she's just done.

What to do About Biting

When you understand that your child's actions are normal, and that they aren't intentional misbehavior, you will be able to take the right steps to teach her how to communicate her anger and frustration. This takes time, and she'll need more than one lesson. Here's how to teach your child not to bite:

Watch and Intercept

As you become familiar with your toddler's actions, you may be able to stop a bite even before it even occurs. If you see that your child is getting frustrated or angry – perhaps in the middle of a tussle over a toy – step in and redirect her attention to something else.

Teach

Immediately after your toddler bites another child, look her in the eye and tell her in one or two short sentences what you want her to know, such as, "Biting hurts. We don't bite. Give Emmy a hug now. That will make her feel better." Then, give your child a few hints on how she should handle her frustration next

time; "If you want a toy, you can ask for it or come to Mommy for help."

Avoid Playful Biting

Nibbling your little one's toes or playfully nipping his fingers sends a mixed message to your child. A little one won't understand when biting another person is okay and when it's not, nor is she able to judge the pressure she's putting into the bite. As she gets a little older, she will start to understand that some things can be done carefully and gently in play, but not in anger. This takes a little more maturity to understand æ more than you can expect your toddler to have at her young age.

First Aid

Although the risk of injury from a toddler's bite is small, it's good to know what to do in case of a bite that breaks through the skin:

- Calm and reassure the child who was bitten.
- Wash your hands with soap and water.
- Wash the wound with mild soap and water.
- Cover the injury with a bandage.
- If the bite is actively bleeding, control the bleeding by applying direct pressure with a clean, dry cloth.
- Call your child's doctor for advice.

Give More Attention To The Injured Child

Typically, we put all our energy into correcting the biter's actions and we don't give the child who was bitten any consolation. Soothing the child who was bitten can show your child that his actions caused another child fear or pain. You can even encourage your child to help sooth his friend.

The Repeat Offender

If you've gone through the above steps, and then your child bites again, you can respond with a little more intensity. If you catch him in the act, immediately go to him. Take him by the shoulders, look him in the eye, and firmly announce, "No biting; time-out." Direct him to a chair and have him sit for a minute or two. It doesn't take very long for your message to sink in. (And, with a toddler, a longer time-out can dilute the message as he may actually forget why he's sitting there!)

If you miss the action, but are told about it later, you can have a talk with your child about what happened. Limit yourself to a few brief, specific comments, as a lengthy lecture is almost never effective. A child who bites a playmate more than once may need more guidance on how to handle frustration and anger. Reading toddler books on the topic, role-playing, and demonstration of appropriate actions can all help your child learn how to respond to his own emotions in socially appropriate ways.

Elizabeth Pantley is a parent educator and the author of many parenting books. This article is a copyrighted excerpt from Gentle Toddler Care (McGraw-Hill, 2006.)

The deepest truth of effective parenting is that it all begins with you as a couple.

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New Parents Are People Too

8 *Secrets to Surviving Parenthood as
Individuals and as a Couple*

Sharon Fried Buchalter, Ph.D.



Caring for Your Whole Child - Coaching Parents in Wholistic Care

By Caron B. Goode, EdD

Your child is a unique blend of traits, habits, and qualities. This blend is what makes her an individual. Therefore, caring for a child demands we address the whole person, not just part of her. While every child must be approached on her level, all children have five basic needs. They are physical, emotional, social, mental, and spiritual. These needs are basic to all human beings, and having them met is crucial to your child's growth and development.

Wholistic Care

Physically – Humans have three basic physical needs. We all need oxygen, water, and food to live. In our world, the quality of these things varies. These differences affect our bodies and how they respond to daily living. Polluted air and toxic water and food does not offer our bodies ample energy. On the other hand, pure air, water, and food allow the body to function at its best. While it is hard to control air and water quality, most parents can control what their children eat. Eating a healthy diet gives your child the strength to meet life head on. That means eating foods that are high in fiber and low in fat. It also means eating enough protein, fruits, and vegetables. In addition, parents should choose foods that are free of additives, preservatives, and food coloring.

Emotionally – Creating a secure environment is the most important way to meet your child's emotional needs. For a child, physical and emotional safety is imperative. Physically, she needs the security that comes from structure and order. This can be obtained by imposing gentle structure on her time, surroundings, and belongings. You may choose to include morning and bedtime rituals, routine meal times, and when age appropriate, chores. Emotionally, she needs a stable environment, which includes knowing her parents or mentors will be there when she needs them. It is from this place of absolute safety that she will develop and mature emotionally.

Socially – All children need support. For younger children, the family fills that role. As children age, however, that changes. They start moving into different communities and develop the desire to belong and achieve. They also begin to want friends and to be part of a larger group. In order for their social needs to be met, children must be encouraged to grow beyond the family. They must also have good role models on which they can build their own brand of social interaction.

As with most things, children model their social behaviors after the ones their parents exhibit. Therefore, it is important your children see you as a friend and community member. Let them see you display acts of kindness and affection. Also, let them see you give and receive social support during times of adversity. By watching you, they will acquire the skills necessary to formulate a support group outside the family. From this group they will learn the importance of friendship, community, and social support.

Mentally – Like the body, the mind requires basic things in order to thrive. Two of the most important things a child needs for mental growth are inspiration and positive self-talk. Inspiration is the key to living well, and realizing ones potential. Encourage your child to find inspiration through the acts of others or through self-reflection. This can be done by journaling, exploring creative outlets or simply reading about the accomplishments of others. Once inspired, your child must believe in herself in order to reach her goals and fulfill her dreams. Believing in oneself is rooted in how we feel about ourselves and what our internal dialog tells us. Helping your child learn positive self-talk can influence all facets of her life. It can affect her confidence, energy level, performance, and relationships with others.

Spiritually – All children want to be connected to something greater than themselves. Younger children depend on their family to fill this spiritual need. As a child matures, however, her circle expands and the need for spirituality grows stronger. It is important that the child understand she is loved and supported by something bigger than she is. This gives her a sense of belonging and establishes faith in herself and the world around her. Parents can help their children develop spiritually by sharing their beliefs and relating them to values shared within the family. This includes introducing your children to religious or spiritual doctrines. It is also important to address the concepts of compassion, love, hope, forgiveness, and faith as well.

*Dr. Caron B. Goode is the founder of the Academy for Coaching Parents International, a training and certification program for parent coaches, the founding editor of the website InspiredParenting.net, and the author of eleven books, the most recent of which is *Help Kids Cope with Stress & Trauma*. For more information visit www.acpi.biz.*

Build a Strong Relationship with Your Child's School

By Raymond J. Huntington

Get Involved – It's Worth It

Did you know that when parents are involved with schools, their children do better in many subjects? Building a strong parent/school relationship means parents and schools communicate actively with each other. By getting involved, you show your child that you value school and education, and you increase your child's chances for success.

Schools vary a great deal in how they communicate with, work with, and welcome parents. Even so, there are things parents can do to foster a relationship.

Get to Know Your Child's Teachers

When school opens (or any other time your child gets a new teacher), go into school and introduce yourself or call or write a note. Make an appointment to meet the teacher and to talk about your child. Describe your child's particular strengths and interests, or areas where your child may need extra help. Teachers appreciate families who take the time and make the effort to get acquainted.

Ask Questions About The Curriculum

For example: Can I visit a class? What is your approach to (a particular subject)? Will my child be placed in a particular ability group? If so, how are the placement decisions made? What "hands-on" materials do you use? What if my child is having problems? Are there things I can do at home to help my child with school-work?

Ask The Teacher To Stay In Touch With You

Ask to be kept informed if things are going well and, especially, if they are not. Make sure the teacher knows your name, has your phone number, and knows what time is easiest to reach you. If problems do arise, it is so much easier to handle them if you already know your child's teacher and have a comfortable relationship with him or her!

Spend Time In School Activities

There are many ways to be involved, including joining parent groups such as the PTO/PTA, attending parent/teacher conferences, or volunteering for a school event or field trip. When a parent offers to help the school in any way, it tells the children, the teachers, and the school administration that this adult cares about the education of his or her child.

Learn What Courses Your Child Needs In Order To Go To College

Ask guidance counselors to explain what course work is needed to meet college requirements, what standardized tests children should take and when to take them, and what the results of these tests mean. Ask the school to sponsor an information session for parents on course selections and college or career planning.

Monitor Homework

Be sure your child is doing his or her homework. One way to let teachers know that you support homework assignments is by signing the homework sheets.

Find Out What Tests Are Given And How The Tests Are Used

A major purpose of tests should be to find your child's strengths and weaknesses and to provide help when needed. Ask your child's teacher how learning is measured and to explain it to you.

Ask The Teacher To Describe The "Hands-On" Activities Your Child Will Experience In Class

Find out if your child gets to use equipment, not just watch someone else use it. Find out if there are problems for children to solve in groups where they can use real materials. If you feel there is not enough active, "hands-on" learning or too much textbook reading and answering end-of-the-chapter questions talk to the teacher about it.

Stay Involved! It's Worth It!

As children move through middle school and high school, they may want their parents to be less involved. Keep connected to the school in ways that are comfortable for your child. Going to a football game, school play, or back-to-school night may do the trick. Strong parent and school relationships can make a big difference in a child's future.

Raymond J. and Eileen Huntington, co-founders of Huntington Learning Center, has provided supplemental education services to local communities for 29 years. Ray Huntington, a doctoral statistician, has served as a business analyst with a Fortune 500 company and an instructor of college-level mathematics and statistics. Eileen, is a former junior and senior high school teacher with a master's degree from Rutgers University.

Helpful Hints to Jumpstart Your Toddler's Education

By Lori Barrett

Attention parents of fast-growing and fast-learning toddlers. Implementing a structured home learning environment for children ages one to five can be beneficial in preparing them for the jump to pre-school or kindergarten, and helping you better manage your days together.

As a child development specialist and co-founder of Thinkertots, a Bayside, New York learning center that provides developmentally enriching programs for children from birth to five years, I recommend ten easy ways to prepare your toddler to be a star student. I believe the saying you are never too old to learn should also say you are never too young. There is a high correlation between an individual's future success and the cognitive stimulation and personality development skills that are formed early in life.

Here are some helpful tips for parents eager to positively influence the educational development of their toddlers:

Routine – Toddlers love to know what to expect. Give them a loosely structured daily routine that includes both free play and learning activities you do together.

Read, Read, Read – Few activities reap the rewards that reading to your child will. Reading helps develop attention span, creative thinking and language while giving you both a close time for bonding. It doesn't matter if she likes to hear the story or if she just wants to actively go back and forth between pages.

Music – Studies show that exposure to different types of music has a positive effect on brain growth and is particularly linked to math ability later on. Play all types of music for her, not just "kids music." This helps make children open to enjoying a variety of musical styles as they grow older.

Library – Make a visit to the library a part of her weekly routine. You want the library to be a fun part of her world. This will contribute to a love of reading and books.

Parent-Child Class – Enroll in an educational parent-child class. As great a parent as you are, you cannot duplicate the learning opportunities children get in a structured group setting with an experienced teacher. You will also enjoy seeing your child blossom socially and learn other ways to continue the learning at home.

Remember that 75% of your child's brain develops before age two, so now is a great time to invest in her education.

Stimulating Trips – At least once a season, take your child on an interesting, educational trip like the zoo, aquarium, farm or museum. Such visits are mentally invigorating and will reinforce learning in other areas.

Computer Programs – There are some outstanding educational software programs for toddlers like Reader Rabbit Toddler. These are fun for her and do a great job of teaching basic concepts. The sooner your child is comfortable and adept at using the computer the better.

Educational TV – TV is not all bad! A few carefully selected programs a week which focus on learning like Dora the Explorer or Blue's Clue's can be a great supplement while providing Mom or Dad with a few minutes of down time.

Foreign Language – If you know another language, now is the time to teach it to your child. Unlike adults, children can easily learn another language without becoming confused. Knowing more than one language is a great asset for a child. Studies also show that learning a second language before age five increases the neural pathways, which benefits all learning.

Helping – It is important for children to learn about helping others and being a part of a team. Give your toddler a simple job like placing empty cans in the recycle bin. Even though this may seem like more trouble than it is worth, it will go a long way to teaching your child responsibility.

A bit of careful planning can make your toddler's daily life one filled with learning, fun and excitement. Taking an early, active role in your child's educational preparedness and development is an investment in time and love that will pay lifelong benefits.

Lori Barrett is a child development specialist and co-founder of Thinkertots, a Bayside, New York learning center that provides developmentally enriching programs for children from birth to five years. Nationwide franchise opportunities are available. For more information, and for additional parenting tips, please visit www.thinkertots.com.

From the Editor

Pediatrics for Parents is almost 27 years old. It's hard to believe I have been publishing the newsletter for that long. (Observant readers will not that this issue is volume 23, not 36 or 27. That's because I have fallen behind.)

My goal when we started *Pediatrics for Parents*, and my goal now, is to help parents be active and informed partners in their children's health-care. I want to provide parents with a parent-friendly but medically based newsletter, and which is different from other magazines for parents. I want you to learn not only what "medical science" is sure about, but also what "medical science" is unsure about. I want you to understand why medicine is both an art and a science. Too often medicine is not as scientific as doctors would like you to believe. That's why doctors have different opinions.

I have a little bad news: beginning next year the subscription cost will increase. Now that the newsletter is longer (16 pages instead of 12) and postal rates have gone up, it costs us more to publish the newsletter. If you renew your subscription by the end of this year – December 31, 2007 – you'll pay the current rate. Starting January 1, 2008, a one-year subscription will cost \$25, two years will cost \$47 and three years will cost \$70.

Have a happy holiday season.

Rich Sagall, MD

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